A VISION PLAN WITH BIG BENEFITS.

Thanks to the purchasing power of the AVMA GHLIT, members and their staff can now benefit from the kind of quality vision coverage and pricing typically reserved for large groups. The AVMA GHLIT sponsored vision plans offer two distinct levels of coverage, allowing each insured to choose the plan that best fits his/her needs. This program, administered by HealthPlan Services, was specifically designed by Ameritas Group, a division of Ameritas Life Insurance Corp. (the plan’s underwriter). Ameritas Group offers vision and dental insurance products nationwide.

### LOW PLAN
- **Monthly Premium**
  - Applicant Only: $3.76
  - Applicant + 1: $7.00
  - Applicant +2 or more: $9.64

### HIGH PLAN
- **Monthly Premium**
  - VSP Choice Network

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>Any Eye Doctor</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Subject to Calendar Maximum</td>
<td>Covered in Full</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Subject to Calendar Maximum</td>
<td>Covered in Full</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Subject to Calendar Maximum</td>
<td>Covered in Full</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Lenticular Vision Lenses</td>
<td>Subject to Calendar Maximum</td>
<td>Covered in Full</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Frames</td>
<td>Subject to Calendar Maximum</td>
<td>$150</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Contact Lenses (Necessary)</td>
<td>Subject to Calendar Maximum</td>
<td>Covered in Full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Contact Lenses (Elective)</td>
<td>Subject to Calendar Maximum</td>
<td>Up to $150</td>
<td>Up to $105</td>
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<table>
<thead>
<tr>
<th>Frequency Allowance</th>
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<tbody>
<tr>
<td>Exams</td>
<td>None</td>
<td>12 Months</td>
<td></td>
</tr>
<tr>
<td>Lens</td>
<td>None</td>
<td>12 Months</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>None</td>
<td>12 Months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible</th>
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<tbody>
<tr>
<td>Exams</td>
<td>$10/Calendar Year*</td>
<td>$25/Calendar Year</td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>$10/Calendar Year*</td>
<td>$15/Calendar Year*</td>
<td></td>
</tr>
</tbody>
</table>

### Maximum (per person)
- Calendar Year Maximum
  - Low Plan: $150
  - High Plan: N/A

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### Included with the Low Plan: Optional non-insurance discounts through access to VSP providers who offer eye wear and services at reduced costs. Plan members can locate a vision provider online by selecting VSP Choice Network at www.ameritasgroup.com, “find a provider.”

### Included with the High Plan:
- If the member exceeds the frame allowance, he/she will receive a 20% discount off the excess amount
- Get up to 20% off additional purchases of complete pair of glasses
- Enjoy 20% off materials not covered by the plan
- Get special pricing on lens options such as ultra-violet coating
- For LASIK and PRK, VSP offers an average discount of 15%. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.

* Deductible applies to the first service received.

These plans are not available to New Hampshire or New York residents. The High Plan is not available to Rhode Island residents. The master group insurance policy providing coverage is governed by the laws of Illinois.
LIMITATIONS

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

ALL PLANS

- exams more than the frequency as indicated on page 1.
- lenses more than the frequency as indicated on page 1.
- frames more than the frequency as indicated on page 1.

FOR THE LOW PLAN

- examinations performed or frames or lenses ordered before the member was covered under the eye care expense benefits.
- subject to extension of benefits, any examination performed or frame or lens ordered after the member’s coverage under the eye care expense benefits ceases.
- sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- non-prescription lenses.
- replacement or repair of lost or broken lenses or frames except at normal intervals.
- any eye examination or corrective eye wear required by an employer as a condition of employment.
- medical or surgical treatment of the eyes.
- coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

FOR THE HIGH PLAN

- contact lenses more than once in any twelve-month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve-month period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the twelve-month period.
- medically necessary contact lenses, except for the first $210 of expense, when such lenses are purchased for any reason other than for the following conditions:
  - following cataract surgery.
  - to correct extreme visual problems that cannot be corrected with spectacle lenses.
  - certain conditions of anisometropia.
  - keratoconus.

Such payment is limited to once in any twelve-month period and is in lieu of lenses and frame benefits under this contract.

- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- the refitting of contact lenses after the initial (90-day) fitting period.
- plano contact lenses to change eye color cosmetically.
- artistically painted contact lenses.
- contact lens insurance policies or service contracts.
- additional office visits associated with contact lens pathology.
- contact lens modification, polishing or cleaning.
- orthoptics or eye care training and any associated testing.
- plano lenses.
- two pairs of glasses in lieu of bifocals.
- lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- medical or surgical treatment of the eyes.
- services for which claim is filed more than 180 days after completion of the service.
- the following materials, over and above the Covered Expense for the basic material. These materials are cosmetic and the member will be responsible for the cost of these materials.
  - blended lenses.
  - oversize lenses.
  - photo chromatic lenses; tinted lenses except pink #1 and #2.
  - progressive multi-focal lenses.
  - the coating of the lens or lenses.
  - the laminating of the lens or lenses.
  - frames exceeding the maximum allowance selected by the Policyholder.
  - corrective vision treatment of an experimental nature.
  - Corneal Refractive Therapy (CRT).
  - costs for services and/or materials exceeding plan benefit allowances.
  - services or materials of a cosmetic nature.
  - any procedure not listed on the Schedule of Eye Care Services.